_____ **COUNTY, TENNESSEE**

IN THE MATTER OF:

_____ **Docket No.** _____

Respondent

REPORT OF PHYSICAL, PSYCHOLOGICAL OR OTHER EXAMINATION

Pursuant to *Tennessee Code Annotated* 34-3-105, the following report of the respondent is made by (Dr.) _____. (Must be performed by Physician or Psychologist)

1. Are you duly licensed to practice in Tennessee? Yes ☐ No ☐

2. Have you made a personal examination of the respondent? Yes ☐ No ☐
If yes, when? _____

3. Briefly describe the medical history of the respondent? _____

_____

_____

4. What is the nature of his/her disability or disabilities? _____

_____

_____

5. Please indicate what your evaluation of the respondent found in any of the following areas:

	Excellent	Good	Fair	Poor	Chronic	N/A
Mental Condition	☐	☐	☐	☐	☐	☐
Physical Condition	☐	☐	☐	☐	☐	☐
Social Condition	☐	☐	☐	☐	☐	☐
Educational Condition	☐	☐	☐	☐	☐	☐
Adaptive Behavior	☐	☐	☐	☐	☐	☐
Social Skills	☐	☐	☐	☐	☐	☐
Impact of current Living conditions on His/her disability	☐	☐	☐	☐	☐	☐

6. Do you feel that the respondent is in need of a Conservator or Guardian to act on his/her best interests?

Yes ☐ No ☐

7. **Indicate the type and scope of Conservatorship or Guardianship that you, in your professional opinion, feel the respondent needs:**

- ☐ **Fiduciary for his/her physical well being**
- ☐ **Fiduciary to handle his/her financial affairs**
- ☐ **Fiduciary to consent to medical treatment**
- ☐ **Fiduciary to consent to relocation**
- ☐ **No Fiduciary needed**

8. **Please indicate your recommendation as to the most appropriate rehabilitation plan. Check all appropriate answers.**

- ☐ **Physical Therapy**
- ☐ **Bed Rest**
- ☐ **Continued Medical Treatment**
- ☐ **No Rehabilitation Plan Feasible**
- ☐ **Other** _____

9. **Is the respondent current currently taking any medication? Yes** ☐ **No** ☐

10. **If Yes, please state the type of medication and the usual dosage:** _____

_____

_____

11. **Please indicate how the medication of the respondent will affect the following. Please check the appropriate response in each category.**

	No Affect	Will Affect	Will Impair	Cannot Determine
Mental Condition	☐	☐	☐	☐
Physical Condition	☐	☐	☐	☐
Educational Situation	☐	☐	☐	☐
Adaptive Behavior	☐	☐	☐	☐
Social Skills	☐	☐	☐	☐

Physician: _____
Address: _____

_____

Date: _____, 20_____

State of Tennessee
County of _____
Sworn to and subscribed before me this ____ **day of** _____, 20 _____.
_____**(Notary Public) My Commission Expires**_____